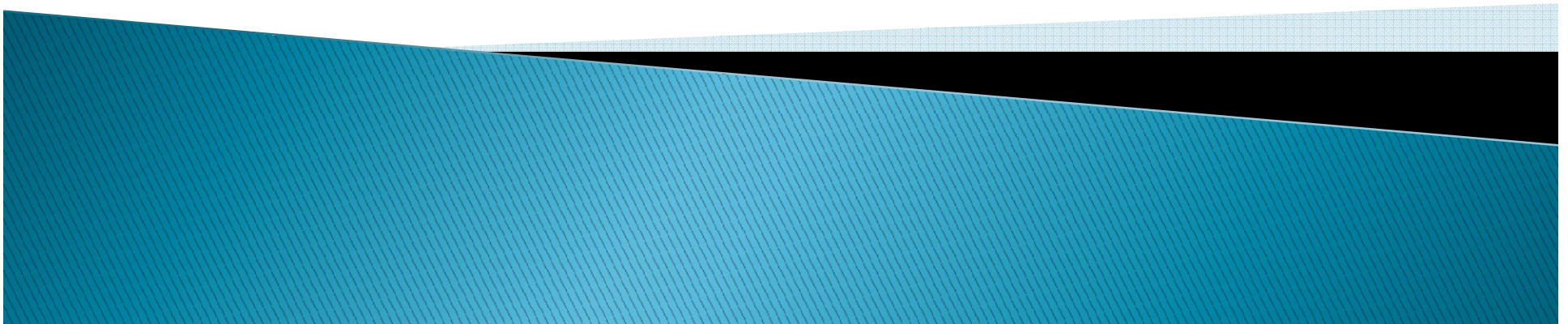


Medicaid Services and Billing: Preventing Common Problems

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Three Categories of Problems

- ▶ Eligibility Problems
- ▶ Clients with Third Party Resources
- ▶ Managing Denied Claims

Eligibility



Categories of Eligibility Problems

- ▶ Eligibility problems may be broken into the following categories:
 - Checking both current eligibility and Medicaid Review Date when beginning services
 - Maintaining eligibility when entering treatment
 - Assisting clients with the eligibility process:
 - How can I help?
 - Understanding unique eligibility rules for children
 - Understanding Medicaid codes that are not really Medicaid (oh, but look like Medicaid!)
 - What to do when a client is denied or has a case closed?

Checking Eligibility and Review Dates

- ▶ When beginning services:
 - Ask for a current Medicaid sticker or Denali KidCare card
 - Find out when the review month is and make a note when the Medicaid Review is due
 - One way to find the review date is to have the client call into the DPA Interactive Voice Response (IVR) to use this option:
 - Have the client call into to the IVR
 - Enter his/her case number (05#) and PIN
 - Select Option 3
 - IVR information is sent to all clients when a DPA case number is registered

Calling the DPA IVR

- ▶ To contact the DPA Information Hotline have the client call:
 - 269-5777 within the Anchorage area or
 - 1-888-804-6330 outside the Anchorage area
 - Enter the 8-digit Medicaid case number beginning with “05”
 - Enter the Security Code which is the last four digits of the client’s Social Security Number
 - Then select Option – 3

Maintaining Eligibility in Treatment

- ▶ When an adult or child enters a residential treatment program:
- ▶ For adults:
 - Have the adult contact Public Assistance and ask Public Assistance to “copy” the center with all DPA correspondence
- ▶ For children:
 - If the child will be in treatment for 30 or more days the child should have a separate Medicaid case established
 - Once the “child only” case is established have correspondence sent to the treatment center

Assisting with Eligibility

- ▶ A case manager can be an Authorized Representative
- ▶ Once established as an Authorized Representative a case manager can:
 - Contact DPA regarding eligibility issues and also participate in the interview
 - Receive copies of all DPA correspondence

Unique Rules for Children

- ▶ When a child is out of parental home for 30 or more days, parental income is no longer “deemed”
- ▶ Out of home means “out of home”
- ▶ Step-parent income is never “deemed” to a child

Codes that Look and Sound like Medicaid

- ▶ Chronic and Acute Medical Assistance:
 - GJ – 21
- ▶ Special Low Income Medicare Beneficiaries (SLMB):
 - ST – 68
- ▶ Disability Exam Coupon:
 - DE – 25
- ▶ Waiver Determination
 - WD – 19

Where to find Help with Eligibility

- ▶ If you are not assigned as an authorized representative and you believe a client's Medicaid has been denied or closed incorrectly:
 - Contact:
 - Lisa Brown or Terry Hamm at DBH
 - Lisa and Terry can speak with DPA without the need for an ROI and assist in trouble shooting

Third Party Resources



What is a Third Party Resource

- ▶ Medicaid is always “payer of last resort” after any and all other insurance, excluding Indian Health Services.
- ▶ Third Party Resources include:
 - Medicare
 - VA Benefits
 - Private / Employer Health Insurance
- ▶ Rehabilitation services do not require third party billing

Medicare

- ▶ Medicare is available to:
 - Persons age 65 or above who have 40 quarters of qualified work
 - Persons who have received 24 months of Social Security Disability Payments (excluding end stage Renal Failure)
 - Adult Disabled Children who had a disability onset prior to age 22

Managing Denied claims



EVS User Link

- ▶ Implementation of the New Integrated Behavioral Health Regulations
- ▶
- ▶ Webpage
at: <http://dhss.alaska.gov/dbh/Pages/Resources/Regulations.aspx>
- ▶ EVS User Guide link at: [EVS User Guide with Behavioral Health Service Limit Codes](#)

Maximum Units Exceeded (238)

- ▶ Identify correct amounts of units to bill based on recipient age, treatment plan, treatment modality, etc
- ▶ Services billed must meet definition for active intervention
- ▶ Therapeutic interventions must align with client's developmental age

Denial Management: Service Authorizations (SA) (550– 558)

► For example:

- From service date outside of effective date on SA:
 - Dates authorized need to match the dates of service billed to Alaska Medicaid
- Verify the SA number and/or dates
 - Correct dates of service on claim
 - Update SA dates of service with Xerox
 - Ensure correct SA number is listed on claim
- Re-bill a corrected claim

Denial Management: Service Limits (i.e. 653)

- ▶ Yearly (SFY) service limit exceeded for aggregate limit of individual, group, and family therapy
 - Recipient has exceeded the yearly limit of 10 hours
 - To correct:
 - Request authorization for additional services
 - Add service authorization number to the corrected claim
 - Re-file the corrected claim

Denial Management: Duplicate Claim (810)

- ▶ Duplicate of previously paid or approved in process claim
 - Two claims are submitted with some or all of the same information:
 - Dates of Service
 - Recipient's ID number
 - Provider's billing ID number
 - Procedure code modifier
 - Reconcile the Remittance Advice (RA)
 - Keep up-to-date records of all paid, denied, pended, and RTD'd claims
 - Reconcile timely
 - Consider adjustment, if claim is already paid

Verify Units Billed are Correct

▶ Remember:

- Modifier U6 reduces billed units to 30 minutes rather than 60 minutes
- Modifier U7 also reduces billed units
- Service Authorizations are approved at the lowest billing units; however, you can bill the procedure code that matches the duration of the service

Denial Management: 278

- ▶ Claim exceeds 12-month filing limit
 - All claims must be filed within 12 months of the date of service
 - A claim denial may be appealed within 180 days from the date of the Remittance Advice
 - Back-dated eligibility can extend the time limit. Back-dated eligibility will be documented with an eligibility letter, which must be included with the back-dated billing. Providers have 1 year from issuance of back-dated eligibility

Questions?



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